No. 76-1188

In the Supreme Court of the United States

OCTOBER TERM, 1976

UNITED STATES OF AMERICA, PETITIONER
v.
WHITECLIFF, INC., D/B/A WHITE CLIFF MANOR

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

DANIEL M. FRIEDMAN,
Acting Solicitor General,
BARBARA ALLEN BABCOCK,
Acting Assistant Attorney General,
RICHARD A. ALLEN,
Assistant to the Solicitor General,
ROBERT E. KOPP,
Attorney,
Department of Justice,
Washington, D.C. 20530.

INDEX

CITATIONS

229 708—77——1

In the Supreme Court of the United States

OCTOBER TERM, 1976

No.

UNITED STATES OF AMERICA, PETITIONER

v.

WHITECLIFF, INC., D/B/A WHITE CLIFF MANOR

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

The Solicitor General, on behalf of the United States of America, petitions for a writ of certiorari to review the judgment of the United States Court of Claims in this case.

OPINION BELOW

The opinion of the Court of Claims (App. A, *infra*) is reported at 536 F.2d 347.[1]

JURISDICTION

The judgment of the Court of Claims was entered on May 12, 1976. A timely motion for rehearing and suggestion for rehearing *en banc* was denied on Sep-

[1] The decision of the Blue Cross Association Medicare Provider Appeals Committee, acting under delegated authority for the Secretary of Health, Education, and Welfare, is set forth at App. C, *infra*.

tember 30, 1976 (App. B, *infra*). On December 22, 1976, the Chief Justice extended the time in which to file a petition for a writ of certiorari to January 28, 1977, and on January 21, 1977, the Chief Justice further extended the time until February 27, 1977 (a Sunday). The jurisdiction of this Court is invoked under 28 U.S.C. 1255(1).

QUESTIONS PRESENTED

1. Whether Section 205(h) of the Social Security Act precludes judicial review of the determination of the Secretary of Health, Education, and Welfare regarding the "reasonable cost" of the medical services performed by respondent as a Medicare provider.

2. If not, whether 28 U.S.C. (Supp. V) 1491 grants the Court of Claims jurisdiction to hear actions brought by Medicare providers for additional reimbursement.

STATUTES INVOLVED

Section 205(h) of the Social Security Act, 49 Stat. 624, as amended, 42 U.S.C. 405(h), pertinent provisions of the Health Insurance For The Aged Act, 79 Stat. 291 *et seq.*, 42 U.S.C. 1395 *et seq.*, and 28 U.S.C. (Supp. V) 1491, are set forth at App. D, *infra*.

STATEMENT

The Health Insurance For The Aged Act (commonly known as the Medicare Act), 42 U.S.C. 1395 *et seq.*, requires the Secretary of Health, Education, and Welfare to reimburse qualified "providers" for the "reasonable cost" of the medical services they furnish to eligible Medicare beneficiaries. 42 U.S.C. 1395g,

1395f(b). The Act provides that "[t]he reasonable cost of any services shall be the cost actually incurred * * * and shall be determined in accordance with regulations establishing the method or methods to be used * * * in determining such costs." 42 U.S.C. (Supp. V) 1395x(v)(1)(A). The Act further provides that such regulations shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive," 42 U.S.C. (Supp. V) 1395x(v)(1)(A)(ii).

Pursuant to the Act, the Secretary has promulgated regulations prescribing certain methods of determining reasonable costs. 20 C.F.R. 405.401 *et seq.* In particular, the regulations prescribe two methods of "cost apportionment" and two methods of "cost finding";[2] they also permit a provider, with prior approval of its financial intermediary,[3] to use a "more sophisticated method" of "cost finding." 20 C.F.R 405.453(d)(2)(ii).

---

[2] In general, "cost apportionment" methods allocate costs between Medicare and non-Medicare patients. 20 C.F.R. 405.452. "Cost finding," on the other hand, involves the distribution of costs among the various departments of the provider's facility without regard to the type of patient being treated. 20 C.F.R. 405.453.

[3] 42 U.S.C. 1395h permits providers to utilize approved public or private agencies, known as fiscal intermediaries, to administer Medicare payments as agents for the Secretary. Pursuant to that provision, the Secretary's regulations provide (20 C.F.R. 405.651(c)): "[F]iscal intermediaries act on behalf of the Secretary, carrying on for him the administrative responsibilities imposed by the law. The Secretary, however, is the real party in interest in the administration of the program."

Respondent, an extended care facility, became a provider of Medicare services in 1966, pursuant to an agreement with the Secretary. In its annual reports to the Secretary for the years 1967 through 1970, respondent used the methods prescribed by the Secretary's regulations for determining its costs. In 1970, respondent conducted a work measurement study, using a single method, not prescribed by the regulations, for both cost apportionment and cost finding. After evaluating the results of this study, respondent submitted a request to its fiscal intermediaries, Blue Cross Association and Blue Cross of Northeast Ohio, that the new method be applied retroactively to the four prior years (1967–1970), which would have resulted in additional reimbursement of $213,755 to respondent. The fiscal intermediaries rejected this request. Respondent appealed to the Blue Cross Association Medicare Provider Appeals Committee, which, after a hearing, also denied the request on the grounds that respondent's proposed method was not authorized by the regulations and that there was not, in any event, any authority for the retroactive application of the new method (App. C, *infra*).

Respondent then instituted this action against the United States in the Court of Claims,[4] asserting that

[4] Respondent originally filed a civil action in the United States District Court for the Northern District of Ohio. That action was dismissed for lack of jurisdiction. *Whitecliff, Inc.* v. *Secretary of Health, Education, and Welfare*, N.D. Ohio, Eastern Division, No. C 73–1027. Respondent filed a notice of appeal but stipulated to dismissal of the appeal shortly before filing this action in the Court of Claims.

the decision of the Provider Appeals Committee was "clearly erroneous and without substantial support as to findings of fact and matters of law" (Complaint, ¶ 31).[5] Respondent sought damages of $213,755.

A panel of the Court of Claims denied the government's motion for summary judgment and rejected the contention that Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), precludes judicial review of the decision of the Provider Appeals Committee. Although the court acknowledged that "[n]o consensus has emerged on whether courts may review the merits of reasonable cost determinations" (App. A, *infra*, p. 3a), it "decline[d] * * * to extend" this Court's interpretation of Section 205(h) in *Weinberger* v. *Salfi*, 422 U.S. 749, "to this Medicare case" (*id.* at 5a). Having determined that Section 205(h) did not bar review, the court concluded that it had jurisdiction under the Tucker Act, 28 U.S.C. (Supp. V) 1491, "both because of [respondent's] contract with the Government and also because the Medicare legislation, fairly read, mandates appropriate payment to providers" (*id.* at 7a).

On the merits, the court held that the decision of the Provider Appeals Committee violated the statute by failing to consider whether respondent's actual costs for the years 1967 through 1970 exceeded the reimbursements it had received under the methods prescribed in the regulations. However, since the

[5] Respondent also alleged that it had been denied due process of law because a majority of the members of the Provider Appeals Committee were employees of the fiscal intermediary (Complaint, ¶¶ 29–30).

court was of the view that "federal courts do not have jurisdiction to try and determine in the first instance a provider's reasonable costs" (*id.* at 11a n. 12), it remanded the case to the Secretary "for a hearing at which [respondent] will be given an opportunity to prove its actual costs and the inadequacy of its reinbursement" (*id.* at 12a).[6]

REASONS FOR GRANTING THE PETITION

This case presents questions of substantial importance to the administration of the Medicare Act. Whether the Court of Claims, or any court, has jurisdiction to review provider reimbursement disputes, and, if so, what issues are open for review, are matters on which the courts of appeals have divided, and the decision below further contributes to the existing confusion.

The Medicare Act has been amended to provide for judicial review of most Medicare provider reimbursement disputes with respect to accounting periods ending on or after June 30, 1973. 42 U.S.C. (Supp. V). 1395oo. But the questions presented have continuing significance because of the number and amounts of pre-1973 claims presently pending and because there are other types of claims under the Medicare Act for which the statute still provides no judicial review. More than 15 cases now pending in the Court of Claims raise the jurisdictional issues

[6] The court did not reach the question whether the composition of the Provider Appeals Committee violated due process (*id.* at 11a–12a).

presented here.[7] In addition, the Secretary estimates that there are more than 150 Medicare controversies pending in the administrative process or in other courts that will be affected by the decision in this case.[8]

1. a. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), is incorporated into the Medicare Act by 42 U.S.C. (Supp. V) 1395ii. The second sentence of Section 205(h) provides:

> No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.[9]

This Court noted in *Weinberger* v. *Salfi, supra,* that Section 205(h) "prevent[s] review of decisions of the Secretary *save as provided in the Act*" (422 U.S. at 757; emphasis supplied) and that "sources of jurisdiction [outside the Act are] foreclosed by [Section

[7] See, *e.g.*, *Town Court Nursing Center* v. *United States*, Ct. Cl. No. 517–70; *Summit Nursing Home, Inc.* v. *United States*, Ct. Cl. No. 89–74; *Wyndover Convalescent Hospital, Inc.* v. *United States*, Ct. Cl. No. 189–73; *Overlook Nursing Home, Inc.* v. *United States*, Ct. Cl. No. 188–72; *Ulman* v. *United States*, Ct. Cl. No. 150–72.

[8] Approximately 81 of those cases, involving claims of more than $10 million, involve provider reimbursement disputes for accounting periods ending prior to June 30, 1973. The remaining disputes involve other provider claims under Part A of the Act, 42 U.S.C. (Supp. V) 1395c *et seq.*, or claims under Part B, 42 U.S.C. (Supp. V) 1395j *et seq.*, with respect to which the Act still provides no review. Those disputes involve claims in excess of $1,020,000,000 (a figure which, however, is inflated by one claim for $1 billion).

[9] For purposes of this provision, "decision of the Secretary" includes the decision of his statutory delegate, such as the Appeals Council (see, *e.g.*, *Weinberger* v. *Salfi*, 422 U.S. 749), or, as in this case, the Provider Appeals Committee.

229-708—77——2

205(h)]" (*id.* at 764). With respect to most Social Security claims, the "herein provided" clause of Section 205(h) refers to Section 205(g), which generally provides for judicial review of "any final decision of the Secretary made after a hearing." See *Weinberger* v. *Salfi*, 422 U.S. 749, 763–764. But when Congress enacted the Medicare Act, it chose not to incorporate Section 205(g). Instead Congress limited review of administrative actions under the Medicare Act to very specific categories of disputes, not including reimbursement claims by Medicare providers. See 42 U.S.C. 1395ff.[10] The limitation of review to certain specific categories of disputes was careful and deliberate. See S. Rep. No. 89–404, 89th Cong., 1st Sess. 54–55 (1965).

In short, judicial review of provider reimbursement disputes pertaining to accounting periods ending before June 30, 1973, was not "herein provided" within the meaning of Section 205(h). Accordingly, Section 205(h) altogether precludes judicial review of the final administrative decision with respect to such disputes. See *Califano* v. *Sanders*, No. 75–1443, decided February 23, 1977 (concurring opinion of Mr. Justice Stewart).

The reasons for the preclusion of review of administrative determinations of the reimbursable

[10] The categories of disputes for which the Act initially provided judicial review were claims by Medicare beneficiaries concerning entitlement to and the amount of benefits under Parts A and B of the Act and claims by providers concerning their status as providers and the termination of that status.

"reasonable cost" of Medicare providers are apparent. In light of the complexities of determining provider reimbursement, which had "been the subject of extended and painstaking debate for more than a decade" (S. Rep. No. 89–404, *supra*, at 35), Congress delegated to the Secretary the authority to determine both what constitutes "reasonable cost" and the methods by which such costs are to be calculated. See 42 U.S.C. (Supp. V) 1395f(b), 1395x(v). Congress reasonably assumed that to permit judicial review of the Secretary's determinations would unduly burden the already considerable administrative task.

The 1972 and 1974 amendments to the review provisions of the Medicare Act support the conclusion that Section 205(h) precludes judicial review of respondent's claim for reimbursement. In 1972, Medicare providers urged Congress to lift the Act's barriers to judicial review. See, *e.g.*, Hearings on H.R. 17550 before the Senate Committee on Finance, 91st Cong., 2d Sess. 679–701 (1970). In response, Congress established both a "Provider Reimbursement Review Board," and, for the first time, a limited right to judicial review for reimbursement disputes. Social Security Amendment of 1972, 86 Stat. 1420–1422, 42 U.S.C. (Supp. III) 1395oo. In 1974, the Act was further amended to provide judicial review for most Medicare provider disputes. Section 3(a) of Pub. L. 93–484, 88 Stat. 1459, 42 U.S.C. (Supp. V) 1395oo. However, in both instances judicial review was made available only with respect to accounting periods ending on or

after June 30, 1973,[11] and only in the district courts. Thus Congress carefully considered the question of judicial review of Medicare provider reimbursement controversies, and it clearly understood and intended judicial review to be precluded for disputes, such as this one, involving pre-1973 periods.

Notwithstanding this legislative history and the unambiguous language of Section 205(h), the court below held that review was available because any other result "would be of doubtful constitutional validity and would undermine the normal presumption in favor of judicial review" (App. A, *infra*, p. 6A).[12] But this Court has now dispelled any notion that statutes precluding review of administrative action are *per se* unconstitutional by holding that in the circumstances there the presumption in favor of review was

[11] Congress reasonably determined that since the providers had theretofore voluntarily participated in the Medicare program knowing that the Secretary's reimbursement determinations were not subject to judicial review, there was no substantial unfairness in continuing the statutory bar to review for past accounting periods.

[12] In *Goldstein* v. *United States*, 201 Ct. Cl. 888, 889, certiorari denied, 414 U.S. 974, the court held that Section 205(h) precludes review of reimbursement determinations except insofar as they "rested on procedures which were constitutionally invalid or violative of the governing statute." Here respondent contended, *inter alia*, that the agency procedures violated due process. But to the extent that claim has merit, and we do not concede that it does, it is not a claim over which the Court of Claims has jurisdiction; the redress of a valid claim of that kind would not be money damages against the United States but rather some form of equitable relief. Such a claim therefore would be cognizable, if anywhere, only in a district court. Thus the question whether Section 205(h) precludes review of colorable constitutional claims is not here presented. Cf. *Johnson* v. *Robison*, 415 U.S. 361.

rebutted by Section 205(h). *Califano* v. *Sanders*, *supra*.

b. The question whether Section 205(h) precludes judicial review of determinations under the Medicare Act for which the Act itself provides no review has engendered substantial litigation in the lower federal courts. The courts have disagreed about the appropriate forum for review,[13] the appropriate standard of review,[14] and the questions subject to review.[15] To the extent that those decisions have undertaken review of reimbursement determinations, they not only have frustrated Congress' express intent to preclude review altogether but also have compounded the difficulties of administering the Medicare program in a coherent fashion. Since the statute continues to limit review to carefully defined categories of disputes, those difficulties will persist as long as the jurisdictional issues presented here remain unresolved.

[13] Compare *Adams Nursing Home* v. *Mathews*, No. 76-1212, decided February 2, 1977 (C.A. 1) (jurisdiction in district courts under 5 U.S.C. 704) with *South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F. 2d 910 (C.A. 2) (jurisdiction only in the Court of Claims).

[14] Compare *Schroeder Nursing Care, Inc.* v. *Mutual of Omaha Ins. Co.*, 311 F. Supp. 405, 408–409 (E.D. Wisc.) (no review of reasonable cost determinations) with *Coral Gables Convalescent Home, Inc.* v. *Richardson*, 340 F. Supp. 646, 650 (S.D. Fla.) (review for substantial evidence). See also *St. Louis University* v. *Blue Cross Hospital Service*, 537 F. 2d 283 (C.A. 8), certiorari denied, No. 76-141 (November 29, 1976).

[15] Compare *St. Louis University* v. *Blue Cross Hospital Service*, *supra* (review generally only of constitutional questions) with *Goldstein* v. *United States*, *supra* (review for compliance with statute).

2. If Section 205(h) does not altogether bar judicial review of disputes of the kind here, the Court of Claims nevertheless erred in holding that the Tucker Act grants it jurisdiction to review such disputes.

This Court recently reaffirmed the limited jurisdiction of the Court of Claims and the principle that waivers of sovereign immunity from suits for money damages, which would give rise to Court of Claims jurisdiction under the Tucker Act, "'cannot be implied but must be unequivocally expressed.'" *United States* v. *Testan,* 424 U.S. 392, 399, quoting from *United States* v. *King,* 395 U.S. 1, 4. The Medicare Act contains no provision indicating an intent to waive sovereign immunity to actions by Medicare providers such as respondent for "actual, presently due money damages." *United States* v. *King, supra,* 395 U.S. at 3. Indeed, the inclusion of Section 205(h) in the Act indicates precisely the contrary.

In addition, the scheme of the Medicare Act refutes the Court of Claims' assertion of jurisdiction to assess money damages for inadequate reimbursement. Throughout the Act, the reimbursement authorized for providers is the reasonable cost of services *as determined by the Secretary pursuant to his regulations.* See 42 U.S.C. 1395g, 1395f(b), and 1395x(v)(1). A determination by the Secretary, not the courts, is the statutory predicate for payment of the amounts due to a provider. Thus even if it were assumed that some judicial review were permitted, the only relief for an unlawful or arbitrary action that would be consistent with the statute would be an order directing the Secretary to exercise his discretion properly in determining

the appropriate level of reimbursement. Indeed, the court below itself recognized that it was without jurisdiction to determine "in the first instance," a provider's reasonable costs (App. A, *infra,* p. 11A n. 12). Since the only appropriate relief, if any, would be equitable in nature, review in the Court of Claims would be inappropriate even if judicial review otherwise were available. *United States* v. *Testan, supra,* 424 U.S. at 404–405.[16]

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

DANIEL M. FRIEDMAN,
Acting Solicitor General.
BARBARA ALLEN BABCOCK,
Acting Assistant Attorney General.
RICHARD A. ALLEN,
Assistant to the Solicitor General.
ROBERT E. KOPP,
Attorney.

FEBRUARY 1977.

[16] The court erroneously relied upon respondent's "contract with the Government" as an alternative basis for Tucker Act jurisdiction. Presumably the court was referring to the agreement filed by respondent pursuant to 42 U.S.C. 1395cc. But that agreement confers no rights on respondent that are independent of the Medicare Act itself. Rather, the filing of the agreement merely made respondent eligible to participate in the program and receive reimbursement of its "reasonable cost" as provided by the Act and under the Secretary's regulations. Since respondent's right to reimbursement is measured by the statute and not by the agreement, the existence of the agreement cannot independently form the basis for Tucker Act jurisdiction.

APPENDIX A

In the United States Court of Claims

No. 407–74
(Decided May 12, 1976)

WHITECLIFF, INC., D/B/A WHITE CLIFF MANOR
v.
THE UNTIED STATES

Before Cowen, *Chief Judge*, DAVIS and KASHIWA, *Judges*.

ON PLAINTIFF'S MOTION AND DEFENDANT'S CROSS-MOTION FOR SUMMARY JUDGMENT

DAVIS, *Judge*, delivered the opinion of the court:

This controversy between a provider of services under the Medicare program and the Government presents primarily a dispute over 42 U.S.C. §1395x(v)(1)(1970),[1] relating to the reimbursement to be made to a Medicare provider. Both parties have moved for summary judgment but we find that we cannot dispose of the case finally.

By contract accepted by the Government in 1966, plaintiff Whitecliff, Inc., operating an extended care facility, became a Medicare provider and thus entitled to reimbursement by the Government for reasonable costs incurred in giving services to Medicare

[1] Statute citations are to the 1970 *Code* unless otherwise noted, because later amendments are inapplicable to this case. All section citations, standing alone, are to title 42 of the *Code*.

229–708—77——3

beneficiaries. Whitecliff designated the Blue Cross Association (BCA) and Blue Cross of Northern Ohio (BCNO) as its fiscal intermediaries.[2]

In 1970 Whitecliff instituted a work measurement program which purportedly revealed that its actual Medicare costs for 1967–1970 exceeded the reimbursement received from the Government. Whitecliff submitted a request for a retroactive adjustment under 42 U.S.C. § 1395x(v)(1) to correct the alleged inadequate reimbursement. BCNO and BCA each denied the request, and Whitecliff appealed to the BCA Medicare Provider Appeals Committee, in accordance with a disputes procedure established by the BCA in 1968. After a hearing, the Appeals Committee upheld BCA's denial of the claim. Whitecliff then filed suit in this court for $213,755, the amount of the alleged underpayment, asserting that it is entitled to a retroactive adjustment and that it was denied due process because the BCA Medicare Provider Appeals Committee was not an impartial decision-maker. The Government defends on the grounds, first, that the social security statute precludes any judicial review of the intermediaries' reimbursement determinations, and, second, that plaintiff's arguments have no merit.

A number of courts have considered the permissibility and scope of judicial review of Medicare provider reimbursement disputes. No consensus has emerged on whether courts may review the merits of reasonable cost determinations (*see, e.g., Schroeder*

[2] A fiscal intermediary is a public agency or private organization which contracts with the Secretary of Health, Education, and Welfare, under 42 U.S.C. § 1395h(a), to determine the amount of reimbursement to be paid to providers and to make the payments. The contract may require the intermediary to perform additional services. *See* 42 U.S.C. §§ 1395h (a), (c).

Nursing Care, Inc. v. *Mutual of Omaha Ins. Co.*, 311 F. Supp. 405, 408–09 (E.D. Wis. 1970) (court may not review amount determined to be reasonable cost); *Temple Univ.* v. *Associated Hosp. Serv.*, 361 F. Supp. 263, 267–70 (E.D. Pa. 1973) (court had jurisdiction to review merits of determination that a certain transfer of funds was restricted and therefore deductible from Medicare reimbursement); *Coral Gables Convalescent Home, Inc.* v. *Richardson*, 340 F. Supp. 646, 650 (S.D. Fla. 1972) (court could not make de novo reasonable cost determination, but court suggested that it might review for substantial evidence after an administrative hearing was held)), but the courts have uniformly sustained judicial review at least for compliance with the Constitution and the governing statue. *See, e.g., Aquavella* v. *Richardson*, 437 F. 2d 397, 400–02 (2d Cir. 1971); *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F. 2d 663, 666–68 (2d Cir. 1973); *Rothman* v. *Hospital Serv.*, 510 F. 2d 956, 958–60 (9th Cir. 1975); *Schroeder Nursing Care, Inc.* v. *Mutual of Omaha Ins. Co.*, *supra* at 409; *Americana Nursing Centers, Inc.* v. *Weinberger*, 387 F. Supp. 1116, 1118–19 (S.D. Ill. 1975); *South Boston Gen. Hosp.* v. *Weinberger*, 397 F. Supp. 360 (W.D. Va. 1975). We accepted this scope of review in our order in *Goldstein* v. *United States*, 201 Ct. Cl. 888, *cert. denied*, 414 U.S. 974 (1973).

The Government contends, however, that the Supreme Court's recent decision in a social security benefits case, *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), implicitly overruled these prior decisions and endorsed the Government's position that there is no review at all of Medicare provider determinations such as the one now before us. In *Salfi* the Supreme

Court ruled that 42 U.S.C. § 405(h)[3] precludes district court review of social security benefit decisions, except insofar as review is authorized elsewhere in the Social Security Act. *Id.* at 756–63. Because Section 1395ii of 42 *United States Code* makes Section 405(h) applicable to the Medicare program, the Government argues that Section 405(h), as interpreted in *Salfi,* prohibits judicial review of all Medicare determinations other than those few for which the act expressly provides review. For the years in question, the act explicitly treats judicial scrutiny of specified Medicare determinations only in 42 U.S.C. § 1395ff, which does not authorize review of the type of decision appealed by plaintiff.[4]

---

[3] Section 405(h) states:

"The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employe thereof shall be brought under section 41 of Title 28 [now the sections of Title 28 delimiting district court jurisdiction] to recover on any claim arising under this subchapter."

[4] 42 U.S.C. § 1395ff(c) entitles an institution to a hearing by the Secretary and to judicial review under Section 405(g) only after a decision to terminate the institution as a provider of services or a determination that the institution is not a provider of services. Other parts of 1395ff cover the rights of individual Medicare beneficiaries to hearings and appeals.

In 1972 and 1974, Congress enacted provisions and amendments greatly expanding statutory review of Medicare provider reimbursement determinations. An amendment of 1972 established a Provider Reimbursement Review Board with jurisdiction to review reimbursement disputes where the amount in controversy exceeds $10,000. Social Security Amendments of 1972, § 243, 86

We decline the invitation to extend *Salfi's* reading of Section 405(h) to this Medicare case. The social security provisions with which the Supreme Court dealt in *Salfi* authorize appeals of all decisions made after hearings, with out limitation as to issues;[5] the practical effect of the *Salfi* decision was simply the enforcement of the Section 405(g) procedures and prerequisites to judicial review. *See also Mathews* v. *Eldridge,* U.S. Sup. Ct. No. 74–204, decided Feb. 24, 1976 (slip op. at 4–10). By contrast, the Medicare statute's express review provisions in effect prior to 1973 apply to extremely limited categories of cases involving providers.[6] To import into the Medicare program the *Salfi* preclusion of judicial review (except as expressly authorized) would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations like the BCA. Such a result would be of doubtful constitutional validity and would undermine the normal

---

Stat. 1420, 42 U.S.C. § 1395*oo*. In 1974 Congress enlarged the review provision of 1395*oo* to grant providers the right to obtain judicial review, in a district court, of any decision of the statutory Board and of any reversal, affirmance, or modification of the Board's decision by the Secretary. Pub. L. No. 93–484, § 3(a), 88 Stat. 1459 (1974), 42 U.S.C. § 1395*oo* (f)(1). These provisions apply only to cost reporting periods ending on or after June 30, 1973.

[5] Section 405(g) entitles any individual who was a party to a hearing to appeal any final decision made after a hearing. Because Section 405(b) entitles any individual prejudiced by an initial decision on an application for benefits to a hearing, the review secured by Section 405(g) potentially covers every benefits decision.

[6] *See* note 4 *supra.*

presumption in favor of judicial review.[7] We cannot assume that the Supreme Court would extend the *Salfi* interpretation of Section 405(h) to Medicare cases, where the consequences would be so dramatically different, and therefore we adhere to the pre-*Salfi* view of judicial review of Medicare provider disputes: Where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable, at least so far as to ensure compliance with statutory and constitutional provisions.[8] In this court, 28 U.S.C. § 1491 (the Tucker Act) is the pertinent jurisdictional provision both because of plaintiff's contract with the Government and also because the Medicare legislation, fairly read, mandates appropriate payment to providers. *Cf. United States* v. *Testan,* U.S. Sup. Ct. No. 74–753, decided March 2, 1976.

---

[7] *See generally Johnson* v. *Robison*, 415 U.S. 361, 366–68, 373–74 (1974); *Barlow* v. *Collins*, 397 U.S. 159, 166–67 (1970); *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F. 2d 663, 667–68 (2d Cir. 1973); Homer & Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 GEO. L.J. 107, 126–29 (1974). In *Salfi* the Supreme Court distinguished *Johnson* v. *Robison*, *supra*, a case in which the Court held that a statute similar to 42 U.S.C. § 405 (h) did not preclude review of the question raised, in part on the ground that review of a constitutional challenge to the statute would have been cut off if the interpretation contended for by the Government in *Johnson* had prevailed, while no constitutional challenges would be denied review under the Social Security Act. *See* 422 U.S. at 762.

[8] For disputes over reimbursements with respect to fiscal periods ending on or after June 30, 1973, Congress has largely resolved the problem of judicial review; only disputes where the amounts in controversy are less than $10,000 are left untreated by statute. *See* note 4 *supra.*

The standard of review set forth in *Goldstein, supra,* encompasses plaintiff's claim for money judgment, based as it is on an allegation that the BCA Medicare Provider Appeals Committee's decision violated the Medicare statute. Relying on 42 U.S.C. § 1395x(v)(1)(B) (1970), which states that the regulations "shall * * * provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive," plaintiff challenges the Committee's rejection of its attempt to use its work measurement study to prove that its Medicare reimbursements for 1967–1970 were inadequate. The Government's position is that it is immaterial that Whitecliff's work measurement study may show that its Medicare reimbursements for 1967–1970 were inadequate. The first leg of the argument is that, under Section 1395x(v)(1), the Secretary of Health, Education and Welfare is authorized to promulgate regulations setting forth the allowable methods for determining costs. The second leg is that the Secretary approved only two pertinent methods—the "departmental" and the "combination," 20 C.F.R. §§ 405.452 (*a*), (*b*)[9]—but did authorize use of a "more sophisticated method" if the provider obtained prospective approval. 20 C.F.R. § 405.453(d)(2)(ii). The third leg is that plaintiff admittedly used the "combination" method and did not seek or obtain advance approval

---

[9] These are methods for allocating or apportioning costs between Medicare patients and the provider's non-Medicare patients. Plaintiff's complaint is that the "combination" method it followed led in its case to inadequate allocation of costs to its Medicare patients. It is this difference for which Whitecliff is suing.

for any other method.[10] It follows, according to the Government, that plaintiff is precluded from any further reimbursement even though it can show that, for its circumstances, the "combination" method led to inadequate reimbursement; the failure to ask for and obtain advance approval of some better method of determining costs is enough to bar the provider.

The answer, we think, is that the statute's retroactivity provision—quoted above—does not permit the Secretary to disregard the significant fact that his two approved methods of cost-determination can lead to inadequate reimbursement in certain circumstances and in particular cases. That was the ruling in *Kingsbrook Jewish Medical Center* v. *Richardson,* 486 F. 2d 663 (2d Cir. 1973), in which the provider maintained, and the Government conceded, that the particular method there involved could result in inaccurate reimbursement in certain situations (including the plaintiff's). The Second Circuit held that the corrective adjustment mandated by 1395x(v)(1) applies wherever a cost method produces an inaccurate reimbursement and was "designed to rectify mistakes made by HEW in formulating a particular method of determining cost." 486 F. 2d at 669, 670. Obviously a regulation permitting a provider to seek a modified cost-method *for the future* is no substitute for the statutory requirement of "suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."[11] The Secretary

[10] *See* note 9 *supra*. Plaintiff's work measurement study did not utilize the "combination" or "departmental" methods.

[11] The Government contends that Section 1395x(v)(1) calls only for an annual adjustment, at year-end, when the total of the interim (monthly or more frequent) payments made under Section 1395g exceeds or falls below the reimbursement calculated on the basis of the cost report filed at year-end. The wording of the statute leaves no room for such an interpretation. It requires adjustment when the "reimbursement produced by the methods of determining costs" proves either inadequate or excessive. Under the regulations, the only reimbursement produced by the cost-determining methods is the reimbursement determined at the end of a fiscal period, after a provider has submitted its cost reports to which these methods are applied. The interim payments are merely monthly (or more frequent) estimates of costs, to which Section 1395x(v)(1) makes no reference. *See* 20 C.F.R. §§ 405.451–.454; *Kingsbrook Jewish Medical Center* v. *Richardson*, *supra*, 486 F. 2d at 669.

cannot excuse his agency or his agents (here, the BCA) from the statutory duty to make such retroactive adjustments by failing to promulgate the prescribed regulation or by using in its place regulations permitting only a prospective change of method and a retroactive adjustment to bring interim payments into agreement with the annual reimbursement produced by a method of determining costs. *See Kingsbrook Jewish Medical Center* v. *Richardson, supra,* 486 F. 2d at 669–70.

The BCA Medicare Provider Appeals Committee therefore violated the Medicare statute when it insisted upon treating plaintiff's work measurement study as an unrecognized method of cost apportionment and found no support in the law or regulations for the requested retroactive adjustment, regardless of the accuracy of the work measurement study. The Committee should instead have determined whether Whitecliff had proved that its actual 1967–1970 Medicare costs (limited by reasonableness) exceeded the reimbursements it received under the "combination" method of determining costs and have granted a retroactive adjustment if Whitecliff had proved its claim that that method was inadequate for Whitecliff's situa-

tion. Because the Committee made no findings on Whitecliff's actual costs for 1967–1970, no comparison of those costs with its reimbursements for those years, and no evaluation of the accuracy of the method under which the provider was paid, we must remand to the Secretary for a hearing at which Whitecliff will be given an opportunity to prove its actual costs and the inadequacy of its reimbursement.[12]

We need not and do not decide plaintiff's remaining contention that the composition of the BCA Appeals Committee violated due process in that three of the five members were BCA employees. However, we note that one district court has found this issue to be substantial and another has ruled that the BCA Committee's composition does deprive a provider of the impartial decision-maker required by cases such as *Goldberg* v. *Kelly*, 397 U.S. 254, 271 (1970). *See Temple Univ.* v. *Associated Hosp. Serv.*, 361 F. Supp. 263, 267 (E.D. Pa. 1973); *St. Louis Univ.* v. *Blue Cross Hosp. Serv., Inc.*, 393 F. Supp. 367, 371 (E.D. Mo. 1975); *Faith Hosp. Serv* v. *Blue Cross Hosp. Serv., Inc.*, 393 F. Supp. 601, 602 (E.D. Mo. 1975).[13] *See also*

[12] 42 U.S.C. § 405(h) seems to us to indicate that federal courts do not have jurisdiction to try and determine in the first instance a provider's reasonable costs. *See* note 3 *supra*.

[13] In decisions issued after this opinion was prepared and adopted, the Eighth Circuit modified the Eastern District of Missouri's decisions in *St. Louis University* and *Faith Hospital*. The Circuit court found, contrary to this district court, that the composition of the Committee is constitutionally permissible but agreed that due process precludes vesting the final determination of the issues in the Committee as constituted. Therefore, the court merely modified the district court's judgment, retaining the requirement that the Secretary make the final determinations. *St. Louis Univ.* v. *Blue Cross Hosp. Serv.*, Nos. 75–1274 & 75–1293 (8th Cir. Apr. 12, 1976); *Faith Hosp. Ass'n* v. *Blue Cross Hosp. Serv.*, Nos. 75–1301 & 75–1344 (8th Cir. Apr. 12, 1976).

Homer & Platten, *supra* note 7, at 131–33. *But see Community Hosp. of Indianapolis, Inc.* v. *Blue Cross Ass'n*, No. IP 73–C–615 (S.D. Ind. Dec. 18, 1974) (composition of Committee does not violate due process). The Secretary could obviate any due process challenge to the decision on remand by providing plaintiff with a hearing before a body not composed in its majority of BCA employees.

In conclusion, we hold that the plaintiff is entitled to a retroactive adjustment[14] in its reimbursement if it can prove that its actual reasonable costs for 1967–1970 exceeded its reimbursement on the "combination" method, but otherwise deny plaintiff's motion for summary judgment, deny the Government's cross-motion, and remand the case to the Secretary of Health, Education, and Welfare pursuant to Rule 149 and our remand statute, Pub. L. No. 92–415, 86 Stat. 652 (1972), 28 U.S.C. § 1491 (Supp. IV, 1974), for a hearing on plaintiff's reasonable costs and the adequacy of its reimbursements for the years 1967–1970, and for a retroactive corrective adjustment[15] if plaintiff proves that its reimbursements were inadequate. Further proceedings in this court are stayed for a period of six (6) months from the date of this decision. Plaintiff's counsel is designated to advise the court by letter, at intervals of 90 days, of the status of the remand proceedings. The parties and the Secretary should also take note of Rule 150.

[14] Subject to any valid regulation, applicable to this case, which may limit the amount of retroactivity of corrective adjustments under § 1395x(v)(1). *See Kingsbrook Jewish Medical Center* v. *Richardson*, *supra*, 486 F. 2d at 670.

[15] See note 14, *supra*.

APPENDIX B

In the United States Court of Claims

No. 407-74

WHITECLIFF, INC., D/B/A WHITECLIFF MANOR

v.

THE UNITED STATES

Before COWEN, *Chief Judge,* DAVIS and KASHIWA, *Judges.*

ORDER

This case comes before the court on defendant's motion, filed August 20, 1976, for rehearing to alter and amend judgment and suggestion for rehearing ***en banc*** pursuant to Rules 7 and 151. Upon consideration thereof, together with defendant's supplemental brief, filed September 21, 1976, without oral argument, by the seven active Judges of the court as to the suggestion for rehearing *en banc* under Rule 7(d), which suggestion is denied,[1] and further having been so considered by the panel listed above as to the motion for rehearing under Rule 151.

IT IS ORDERED that defendant's said motion for rehearing, filed August 20, 1976, be and the same is denied.

By the Court.

WILSON COWEN, *Chief Judge.*

---

[1] Judge Skelton would allow defendant's suggestion for rehearing *en banc.*

APPENDIX C

Blue Cross Association, Medicare Provider Appeal—Committee Decision

Dispute Between Whitecliff Manor and Blue Cross of Northeast Ohio

This provider appeal of a dispute between an ECF and the Blue Cross Plan was heard by the Blue Cross Association Medicare Provider Appeals Committee on May 10, 1972, Gerald M. Green, BCA, presiding. Other members on the Committee hearing and deciding were Wade Mountz and Eugene L. Staples. AHA; and North S. Hinkle and H. Walter Moeller, BCA. The provider was represented by its president, its administrator, and its counsel. The Plan's position was presented by a member of the Federal Programs staff of the Blue Cross Association. The decision of the Committee was based upon presentations and responses to questions during the hearing, including the documents furnished the Committee before and during the hearing.

The dispute concerned the Plan disallowance of provider's claim for reimbursement based on an accurate allocation of nursing division costs between Medicare and self-pay patients.

The Plan disallowed the provider's request to use what the Plan considers a modification of the acceptable methods of cost apportionment recognized by the Regulations. The Plan argued that a provider has the option of choosing either departmental or combi-

nation method of apportioning costs to beneficiaries, but beyond these two methods there is no provision in the Regulations for any other methods of apportionment.

The Plan recognized that the approved methods of apportionment may not in all instances result in an accurate allocation of costs to beneficiaries. However, the Plan was unable under existing Medicare Regulations to approve any alternative method of apportionment. Therefore, the Plan felt compelled to deny the provider any further consideration of the request for use of an alternative method of apportionment.

The provider contended that Regulations Sections 405.401(d), 405.402(a), 405.402(b)(3), 405.403(b), 405.403(c), 405.403(g), and 405.453(d)(2)(ii) supported its request for retroactive adjustment as computed utilizing its work measurement study for the allocation of nursing costs between Medicare and self-pay patients. The provider further quoted Public Law 89–97, Title XVIII, Part C. Section 1861(c)(1) which states in part "provide for the making of suitable retroactive corrective adjustments where, for providers services for any fiscal period, the aggregate reimbursement produced by the methods of determining cost proves to be either inadequate or excesisve."

Further, the provider contended that its work measurement study has resulted in a more accurate and refined cost determination comparable to that which results from distinct part certification which is its present method of operation as of January 1, 1971. As a result of its study and its effect upon Medicare reimbursement, the provider requested a retro-

active adjustment for these years ending 1967, 1968, 1969, and 1970.

The Committee observes a number of conditions which have resulted in the provider's financial situation. These conditions include the following observations: (1) the institution had more than one level of care in the periods in question, including pure custodial care; (2) there were options open to the provider's management in 1965 which included (a) establishing a differential rate structure based on an evaluation of patient needed admission, (b) establishment of separate wings for different levels of care, or (c) establishment of total utilization review which would have lowered their occupancy and thereby increased Medicare utilization and subsequent Medicare burden of expenses; (3) the financial loss claimed by the provider could be attributed to such factors as a new facility opening with substantial start-up cost, low occupancy rates, and an apparent inadequate charge structure; (4) the provider's utilization review committee performed only in conjunction with Medicare patients, which, while not against the law, is contrary to Medicare program policy and the Joint Commission of American Hospital policy; (5) the Committee acknowledges that the provider has employed good management in an attempt to do a good job, however management has chosen a double standard under which it operates in caring for Medicare and non-Medicare patients.

In conclusion, the Committee finds no basis in the Regulations for the provider's requested method of apportionment as such method is outside those recognized. The Committee further acknowledges that there is no question that the Regulations do not provide an

exact method of costing for each item of service provided Medicare and non-Medicare beneficiaries, and to do so would be a statistical nightmare. The Regulations do provide, however, acceptable methods of apportioning costs between Medicare and non-Medicare patients which are equitable to providers of services in the program. This provider, however, has made management decisions which have had direct effects upon its reimbursement. [This Committee does not purport to judge the exercise of the provider's management prerogatives but as stated finds no basis in the Law and Regulations to support the provider's request for a retroactive change in accounting methods which would, to a certain extent, result in duplicate payments to this provider.]

Therefore, the Committee unanimously upholds the Plan's decision.

APPENDIX D

1. 28 U.S.C. (Supp. V) 1491 provides in pertinent part:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. * * * In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just.

* * * * *

2. Section 205(h) of the Social Security Act, 49 Stat. 624, 42 U.S.C. 405(h) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or government agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

3. The Health Insurance For The Aged Act (hereinafter the "Medicare Act"), 79 Stat. 297, 42 U.S.C. 1395g, provides in pertinent part:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid * * * the amounts so determined * * *.

4. The Medicare Act, 79 Stat. 296, as amended, 42 U.S.C. (Supp. V) 1395f(b), provides in pertinent part:

> The amount paid to any provider of services * * * shall * * * be—
> (1) the lesser of (A) the reasonable cost of such services, as determined under section 1395x (v) of this title, or (B) the customary charges with respect to such services * * *.

5. The Medicare Act, 79 Stat. 322, as amended, 42 U.S.C. (Supp. V) 1395x(v)(1)(A), provides:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other

> things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider

of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

6. The Medicare Act, 79 Stat. 322, as amended, 42 U.S.C. (Supp. V) 1395ii, provides:

> The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

U.S. GOVERNMENT PRINTING OFFICE: 1977